	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	= IED
		011129	B. WING		02/24/2016	
NAME OF PF	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 02/2	4/2010
DDOOKD	N E HOME HEALTH IND	5354 W 62N				
BROOKDA	ALE HOME HEALTH INDI	ANAPOLIS	DLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 000	0 Initial Comments		N 000			
	This survey was a State relicensure survey. The survey was extended.					
	Survey dates: Februa 2016	ary 17, 18, 19, 23, and 24,				
	Facility ID#: 011129					
Provider #: 157582						
	Census: 80					
N 470	410 IAC 17-12-1(m) Fadministration/manag	- ·	N 470			
	Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This RULE is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 1 of 6 home visit observations. (# 3)					
	Findings include:					
	using an alcohol - bas performed: A. Before patients. B. Before a the visit bag. C. Before when perfomring steri	3. Hand decontamination				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
		011129	B. WING		02/2	24/2016
NAME OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA	TE, ZIP CODE		
BROOKDA	ALE HOME HEALTH IND	ANAPOLIS 5354 W 62	ND SI OLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
N 470	After contact with a praking a pulse, blood E. After contact with mucous membranes, wound dressings, if h contaminated. F. Wh contaminated body siduring patient care. Contaminate objects, incin the immediate vicin removing gloves. I. A to leaving the patient of leaving the leaving t	atient's intact skin (when pressure or lifting a patient. body fluids or excretions, non - intact skin, and ands are not visibly nen moving from a te to a clean body site 3. After contact with cluding medical equipment, aity of the patient. H. After After completing care, prior is home " Intaminated Materials 2/2012, indicated " 3. ning reusable equipment that with mucous membranes or ears to equipment that from patient to patient in the duties, i.e., BP [blood oscope, thermometers, exposed portions of oil or other appropriate Intaminated Waste 2/2012, indicated " 3. wastes [disposable floves, towels, tubings dressings, d in a plastic puncture ured. It should be double ole, placed in a plastic trash I and labeled as appropriate Is ease Control Standard I. Standard Precautions	N 470			

Indiana State Department of Health

STATE FORM 6899 U7Y411 If continuation sheet 2 of 74

PRINTED: 04/05/2016 FORM APPROVED

Indiana State Department of Health

NAME OF PROVIDER OR SUPPLIER BROOKDALE HOME HEALTH INDIANAPOLIS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 5354 W 62ND ST INDIANAPOLIS, IN 46268 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER BROOKDALE HOME HEALTH INDIANAPOLIS S354 W 62ND ST INDIANAPOLIS, IN 46268 ((A) ID PREFIX TAG ((A) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 470 Continued From page 2 IN 470 Continued From page 2 In PREFIX TAG N 470 Continued From page 2 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 470 N 470 N 470 N 470 N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 470 N 470 N 470 N 470 N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 470 N 470 N 470 N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 470 N 470 N 470 N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 470 N 470 N 470 N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 470 N 470 N 470 N 470 N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 470 N 470 N 470 N 470 N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY N 470 In Variable Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY IN 470 IN				A. BUILDING: _			
BROOKDALE HOME HEALTH INDIANAPOLIS (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 470 Continued From page 2 touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during			011129	B. WING		02/	24/2016
INDIANAPOLIS, IN 46268 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 470 Continued From page 2 N 470	NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
INDIANAPOLIS, IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) N 470 Continued From page 2 touching of surfaces in close proximity to the patient to prevent both contaminated hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces. I. Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inamimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during	BBOOKDAL	LE HOME HEALTH IND	5354 W 62	ND ST			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) N 470 Continued From page 2 touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces. Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during	BROOKDAL	LE HOME REALTH IND	INDIANAF	POLIS, IN 46268	}		
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are moved in and out of patient rooms frequently IV.B. Personal protective equipment (PPE) IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin could occur. " 5. A home visit was made to patient number 3, with Employee C, a registered nurse, on 02/18/16 at 10:30 AM. Employee B, was observed providing wound care to the patient's left heel. The patient's primary diagnosis was necrotizing fascities [flesh eating disorder]. Employee B was observed to clean hands and applied gloves, remove the patient's sock and stocking, cut the patient's kerlix wrap and removed a soiled		touching of surfaces patient to prevent both hands from environme transmission of pathochands to surfaces IV.A.3.a. Before having patients. IV.A.3.b. A fluids or excretions, in nonintact skin, or work after contact with a pushen taking a pulse of patient). IV.3.d. If ha contaminated-body suring patient care. I inanimate objects (inclinated by the immediate vicing and disinfect that are used by patient care moved in and out IV.B. Personal procedures for preventional	in close proximity to the h contamination of clean ental surfaces and gens from contaminated Perform hand hygiene: ing direct contact with fter contact with blood, body nucous membranes, and dressings. IV.A.3.c. atient's intact skin (e.g., or blood pressure or lifting a ands will be moving from a lite to a clean-body site V.A.3.e. After contact with cluding medical equipment) inity of the patient. IV.A.3.f. is IV.F.5. Include equipment in policies and inting contamination and for tion, especially those items ents, those used during re, and mobile devices that a of patient rooms frequently stective equipment (PPE) 2.a. Wear gloves when it inticipated that contact with fectious materials, mucous ct skin, or potentially skin could occur. " made to patient number 3, registered nurse, on 02/18/16 yee B, was observed to the patient's left heel. diagnosis was necrotizing disorder]. Employee B was not and applied gloves, sock and stocking, cut the				

Indiana State Department of Health

STATE FORM 6899 U7Y411 If continuation sheet 3 of 74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X			X3) DATE SURVEY COMPLETED	
		011129		B. WING		02/2	4/2016
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKDA	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62N				
(X4) ID PREFIX		ATEMENT OF DEFICIENC Y MUST BE PRECEDED B	IES	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORI		TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE
N 470	- Community Company			N 470			
ı	B continued to clean the patient's wound, applied solosite wound gel around the patient's wound. Continuing to not change his / her gloves, Employee B removed and cut a piece of medicated dressing with the same scissors that was used to to remove the kerlix without cleaning to prior use. Employee B proceeded to apply the medicated dressing, 4 x 4, foam dressing, then wrapped the foot with kerlix. At this time, Employee B removed his / her gloves and cleaned hands with hand gel. Employee B						
	cleaned the patient area of soiled dressings with his / her bare hands and carried it to the patient's						
	his / her bare hands a kitchen and placed th						
	can. Employee B cle	aned her hands and	d applied				
	gloves, obtained a blo patient's finger, remo	•					
	the patient's blood, put his / her traveling bag	ut the hand held ma					
	6. Employee C, Regi		/16.				
	Employee C was una with infection control.		ner error				
N 484	410 IAC 17-12-2(g) Comprovement	A and performance	e	N 484			
	Rule 12 Sec. 2(g) All services shall mainta						
	to assure that their ef						
	complement one and objectives of the patie						
	communication and the						
	documented in the clicase conferences.	inical record or minu	iles Ui				
	This RULE is not me	•	e agency				
	Based on interview and record review, the agency		c agency				

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STATE FORM 6899 U7Y411 If continuation sheet 4 of 74

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011129	B. WING	<u> </u>	02/24/2016
	ROVIDER OR SUPPLIER ALE HOME HEALTH IND	IANAPOLIS 5354 W	ADDRESS, CITY, STATE 62ND ST APOLIS, IN 46268	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
N 484	effectively and docum providing service to perfectively and docum receiving therapy ser 7, 8, and 9) Findings include: 1. Clinical record numericulated a plan of cast for the certification per with orders for skilled and occupational them. a. Review of the evaluation visit dated was no coordination occupational therapist fail were coordinated effective was no coordinated effective. b. Review of the evaluation visit dated was no coordinated effective. b. Review of the evaluation visit dated was no coordinated effective. 2. Clinical record numericulated a plan of cast for the certification per with orders for skilled and occupational the effective.	efforts were coordinated nented with all disciplines satients coordinated nented for 3 of 9 patients vices in a sample of 12. (# mber 7, SOC 01/27/16, re established by a physician eriod of 01/27/16 to 03/26/16, a nursing, physical therapy, rapy. It is physical therapy initial 01/27/16, indicated there of services with the est and skilled nursing. The ed to ensure his / her efforts ectively. It is occupational therapy initial 02/03/16, indicated there of services with physical ursing. The occupational sure his / her efforts were by. In occupational therapy initial o2/03/16, indicated there of services with physical ursing. The occupational sure his / her efforts were by. In occupational therapy initial o2/03/16, indicated there of services with physical ursing. The occupational sure his / her efforts were by. In occupational therapy initial o2/03/16, indicated there of services with physical ursing. The occupational sure his / her efforts were by.	N 484	DEPICIENCY)	
	evaluation visit dated was no coordination occupational therapis	e physical therapy initial 11/18/15, indicated there of services with the at and skilled nursing. The ed to ensure his / her efforts			

Indiana State Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		011129	B. WING		02	/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 63				
	CLIMMADY CT		POLIS, IN 46268	PROVIDER'S PLAN OF	F CORDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 484	Continued From page	e 5	N 484			
	were coordinated effe	ectively.				
	 b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively. 3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16 with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively. 					
	evaluation visit dated was no coordination o occupational therapis	t and skilled nursing. The ed to ensure his / her efforts				
	Manager on 2/24/16 a stated therapy would the team members ar	and Therapy Service at 12:00 PM. Employee M "typically" coordinate with ad put a note in the care the computer for everyone to				
	12/2012, indicated " . between team member	ntinuity of Care" dated Periodic communication ers concerning the patient's needs as evidenced in case				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		011129	B. WING		02/2	24/2016
	ROVIDER OR SUPPLIER	53:	REET ADDRESS, CITY, STA	TE, ZIP CODE		
		INI	DIANAPOLIS, IN 46268	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 484	optimize visit schedul patient and the care to the car	nd clinical notes F. ween multiple disciplines to es for the benefit of the o be provided " se Conference / Progress 2012, indicated " Case de utilization review; s - both direct and contract with patients will participate				
N 486	coordinate its service service providers service providers service providers service. This RULE is not me Based on interview at failed to ensure their effectively and documenters that was furnity records reviewed (#22 receiving outside service). The clinical record reviewed on 02/18/16 record had a plan of a physician for certification.	te home health agency shat is with other health or social wing the patient. It as evidenced by: Indirected review, the agency of the patient were coordinated in the dialysis is shing services for 2 of 2 and 11) of patients wices in a sample of 12. If for patient number 2 was at 10:30 AM. The clinical	су			
	and 1 day a week for a. A home visit f	wo days a week for 3 week two weeks. or patient number 2 occurr .M. During the home visit				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
0	11129	B. WING		02/24/2016	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKDALE HOME HEALTH INDIANAPOL	.IS 5354 W 621				
		OLIS, IN 46268			
(X4) ID SUMMARY STATEMENT (PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENT	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
N 486 Continued From page 7	Continued From page 7				
the patient was observed to hon the her left forearm. Where whether she was currently recepatient number 2 stated that son Monday, Wednesday, and the care coordination notes, the evidence coordination of care agency and the dialysis center. 2. Clinical record number 11, included a plan of care estable physician for the certification physician for the dialysis care coordination notes, the algorithm evidence on Renal Dialysis care coordination notes, the algorithm evidence coordination of care agency and the dialysis center. 3. An interview with the Adm 02/18/16 at 2:25 PM, stated the "not typically keep records from communicate directly with the 4. A policy titled "Continuity of 12/2012, indicated " Period between team members concept progress and special needs a conference reports and clinical Coummunicating between multiple physical physica	an questioned as to be	N 486			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02/24/20	016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKDA	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 621	ND ST OLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE Co	(X5) OMPLETE DATE
N 504	Continued From page	e 8	N 504			
N 504	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights	N 504			
	Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 6 of 12 records reviewed (# 1, 3, 6, 7, 11, and 12)					
	Findings include:					
	 Clinical record number 1, SOC (start of care) 05/15/15, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/18/16. The "Consent For Treatment" section failed to evidence a frequency for skilled nursing. Clinical record number 3, SOC 01/18/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/18/16. The "Consent For Treatment" section indicated skilled nursing, home health aide, physical therapy and occupational therapy was to be provided. The 					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICAT	IION NUMBER:	A. BUILDING: _		COMP	LETED	
	011129		B. WING		02/	24/2016	
NAME OF PROVIDER OR SUPPL	≣R	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
BROOKDALE HOME HEAL	H INDIANAPOLIS	5354 W 621 INDIANAPO	ND ST DLIS, IN 46268	3			
PREFIX (EACH DE	ARY STATEMENT OF DEFI ICIENCY MUST BE PRECE RY OR LSC IDENTIFYING I	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
The admitting of the visits proskilled nurse at a 3. Clinical recordan "Admission signed and data representative Treatment" see physical theraphe provided. The provided of a 1 and failed to inform advance about proposed to be a 1. Clinical recordan "Admission signed and data representative Treatment" see times a week for occupational the weeks. a. The addigate patient / representative note in the provided of the provided of the provided. The provided of the	ated "eval [evaluate] linician failed to infor in advance about the posed to be furnished home health aide. In advance about the posed to be furnished home health aide. In advance about the posed to be furnished by the patient and on 02/17/16. The "Cotion indicated skilled y and occupational the frequency indicate reat." The admitting the patient / represe the frequency of the furnished by the skilled or on 01/27/16. The "Cotion indicated skilled on 01/27/16. The "Cotion indicated skilled or six weeks, physical erapy two times a week in advance are evisits proposed to be a six of the proposed to be a six of t	m the patient le frequency d by the 2/17/16, had eement" l agency onsent For nursing, herapy was to ed "eval clinician ntative in visits led nurse. 1/27/16, had eement" l agency onsent For nursing two onsent For nursing two I therapy and eek for six I to inform the about the be furnished rehensive /16, the refused skilled lician also osed to a one	N 504				

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) D. CO			
		011129	B. WING		02	/24/2016
NAME OF PROV	IDER OR SUPPLIER	STR	REET ADDRESS, CITY, STATE	E, ZIP CODE	-	
BROOKDALE	HOME HEALTH IND	IANAPOLIS	64 W 62ND ST DIANAPOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
ev the free ind age ev the free ind age ev the free ind age or occurrence or occurrenc	raluation visit note of erapy assessment requency of the proportion of the patient of preement with the patient of the raluation visit note of erapy assessment requency of the proportion of the proposed o	e physical therapy initial dated 01/27/16, the physical plan failed to include the cosed visits and failed to / representative was in plan of care. e occupational therapy initial dated 02/03/16, the speech plan failed to include the cosed visits and failed to / representative was in plan of care. mber 11, SOC 10/18/15, had of care by a physician for the 0/18/15 to 12/16/15, with sing, physical and services. The "Consent for ailed to include physical and services. The admitting	d d d d d d d d d d d d d d d d d d d			

Indiana State Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		011129	B. WING		02/24/2	2016
	ROVIDER OR SUPPLIER ALE HOME HEALTH IND	S354 VIANAPOLIS	r address, city, state V 62ND ST NAPOLIS, IN 46268	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
N 504	include the frequency failed to include if the in agreement with the b. Review of the evaluation visit note of therapy assessment if frequency of the propinclude if the patient // agreement with the p	assessment plan failed to of the proposed visits and patient / representative was plan of care. speech therapy initial lated 11/13/15, the speech plan failed to include the osed visits and failed to representative was in lan of care. was unable to provide any tion and/or information	N 504			
N 522	written medical plan of periodically reviewed chiropractor, optomet This RULE is not me	edical care shall follow a of care established and by the physician, dentist, rist or podiatrist, as follows: t as evidenced by:	N 522			
	failed to ensure the p ongoing wound treatr goals for 1 of 12 reco ensure the plan of ca physicians that the cli from for 1 of 12 recon nurses follow the nurs care for 3 of 9 records occupational and phy therapy frequency in records reviewed (# 9	nicians can accept orders ds reviewed (# 3); skilled sing frequency in the plan of s reviewed (# 8, 9, 10); sical therapy follow the the plan of care for 2 of 9				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
BROOKD	ALE HOME HEALTH INI	DIANAPOLIS	62ND ST APOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 522	(# 9), and failed to for for 1 of 5 records revivounds. (#10) Findings include: 1. Clinical record nuincluded a plan of cafor the certification produced and plan of care failed and legs, applied wrapped with kerlix, The plan of care failed and goals that were considered the site with plan of care failed and goals that were considered the plan of care indicated the pla	patients with PT/INR orders ollow wound treatment orders viewed of patients with amber 3, SOC 01/18/16, are established by a physician eriods of 01/18/16 to e OASIS comprehensive ent dated 01/18/16, the dicated the patient had Other diagnoses included onary heart disease, restless ic pancreatitis, and long term	N 522			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02	:/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	, ,	
BBOOKD	ALE HOME HEALTH IND	5354 W	62ND ST			
BROOKD	ALE HOME HEALTH IND	INDIANA	APOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 522	Continued From page	e 13	N 522			
	of care failed to be specific in the acceptance of physician orders.					
	11/18/15, included a physician for the certion 01/16/16, with orders a week for one week.	mber 8, SOC [start of care] plan of care established by a ification period 11/18/15 to for skilled nursing one time, two times a week for 2 a week for one week.				
	a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care.					
	indicated a new skille time a week for one wevery other week time 12/27/15 to 01/02/16 visits and during the 01/09/16, the skilled of the patient without a	order dated 12/20/15, ed nursing frequency of one week then one time a week es 2. During the week of , the skilled nurse made two week of 01/03/16 to nurse made one extra visit to physician's order. The ofollow the plan of care.				
	included a plan of car for the certification pe with orders for skilled one week then two tin and occupational the four weeks starting w	mber 9, SOC 01/14/16, re established by a physician eriod 01/14/16 to 03/13/16, I nursing one time a week for mes a week for six weeks rapy two times a week for yeek starting 01/17/16.				
	indicated effective 01 to see the patient two three times a week for	order dated 01/20/16, /24/16, the skilled nurse was times a week for one week, or two weeks, then two times Review of the skilled				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		
		011129	B. WING	 	02/24/2016
NAME OF P	ROVIDER OR SUPPLIER		FADDRESS, CITY, STATE	E, ZIP CODE	
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	V 62ND ST NAPOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETE
N 522	made an extra nursir during the week of 2/third nursing visit dur. The skilled nurse fail. b. Review of the notes, indicated the oto make a second vis 01/21/16. The occup follow the plan of car. c. A physician's indicated for skilled in PT/INR on 02/23/16. evidenced the skilled 2/18/16, and obtaine nurse failed to follow. 4. Clinical record nuincluded a plan of cafor the certification powith order for skilled one week, two times then one time a weel and teach decubitus cleanse with normal foam dressing. a. Review of the made a visit on 2/9/1 nurse failed to follow. b. Review of the 2/09, 02/12, 02/16, 0 wound care section in provided decubitus cleanse with normal in normal should skin barrier.	dicated the skilled nurse ag visit (total of three visits) (24/16 and failed to make a ing the week of 02/07/16. ed to follow the plan of care. e occupational therapy visit occupational therapist failed sit during the week of oational therapist failed to e. order dated 02/09/16, nursing to recheck the The clinical record a nurse made a visit on dethe PT/INR. The skilled the plan of care. mber 10, SOC 12/10/15, re established by a physician eriod 02/09/16 to 04/04/16, nursing one time a week for a week for three weeks, of for two weeks to perform care to left upper buttock, saline, pate dry, cover with established nursing visits, a LPN 6 and 2/12/16. The skilled the plan of care. e skilled nursing visits on 2/19, and 02/23/16, the indicated, "wound care is care to L [left] buttock	N 522		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	ANAPOLIS	/ 62ND ST IAPOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 522	10/18/15, included an the certification period with orders for physic for one week and occ a week for one week. therapy failed to follow 6. The Administrator Services was unable documentation and/or 2/24/16 at 2:20 PM. 7. A policy titled "Car 12/2012, indicated " . include Food or druoutcomes to be achie treatments supplies Frequency and duratidecisions and services."	nber 11, SOC (start of care) established plan of care for d of 10/18/15 to 12/16/15, al therapy one time a week upational therapy one time Physical and Occupation w the plan of care. and Director of Clinical to provide any additional r information when asked on e Planning Process" dated The clinical plan of care ug allergies goals / ved medications and s and equipment required	N 522			
N 524	and outcomes " 410 IAC 17-13-1(a)(1 Rule 13 Sec. 1(a)(1) of care shall:	ponse to care against goals Patient Care As follows, the medical plan consultation with the home	N 524			
	(B) Include all service service is being provide (B) Cover all pertiner (C) Include the follow (i) Mental status.	nt diagnoses.				

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NAME OF PROVIDER OR SUPPLIER BROOKDALE HOME HEALTH INDIANAPOLIS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 5354 W 62ND ST INDIANAPOLIS, IN 46268 (X5)		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER BROOKDALE HOME HEALTH INDIANAPOLIS S354 W 62ND ST INDIANAPOLIS, IN 46268 CAN ID SUMMARY STATEMENT OF DEFICIENCIES CAN ID PREFIX CAN ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DORRECTIVE ACTION SHOULD BE PREFIX TAG	AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COM	-LETED
STATE STAT			011129	B. WING		02	/24/2016
CX4 ID SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION (CX5)	NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	TE, ZIP CODE		
INDIANAPOLIS, IN 46288 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL RESULTORY OR LIST DE PRECEDED BY FULL RESULTORY OR LIST CIDENTIFYING INFORMATION) N 524 Continued From page 16 (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (ix) Medications for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, altergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed. (# 1, 2, 3, 5, 6, 7, and 11) Findings include: 1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16	BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354	W 62ND ST			
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) N 524 Continued From page 16 (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (viii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed. (# 1, 2, 3, 5, 6, 7, and 11) Findings include: 1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16			INDIA	NAPOLIS, IN 4626	3		
(iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vii) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed. (# 1, 2, 3, 5, 6, 7, and 11) Findings include: 1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks. a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to	N 524	(iii) Frequency and (iv) Prognosis. (v) Rehabilitation p (vi) Functional limitation p (vii) Activities permitation in the control of the c	duration of visits. actions. atted. rements. ad treatments. asures to protect against timely discharge or referral. ties specifying length of priate items. as evidenced by: ew and interview, the agency evise the plan of care to as taken by the patient, allergies, interventions and ad outside services being ecords reviewed. (# 1, 2, 3, at 10:30 AM. The clinical shed plan of care signed by ification periods of 02/13/16 ers for skilled nursing one reek, two days a week for 3 week for two weeks. for patient number 2 occurred and. During the home visit rved to have a dialysis fistula	N 524			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		011129	B. WING		02	2/24/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
вкоокі	DALE HOME HEALTH IND	IANAPOLIS	62ND ST APOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
N 524	patient number 2 star on Monday, Wednes dated 02/13/16, state renal failure and has Wednesday and Frid (POC) failed to indicareceiving dialysis treat b. A home visit fron 02/18/16 at 9:30 A the patient stated that diet with fluid restriction indicated that the patient stated that diet with fluid restriction indicated that the patient stated that the patient stated that diet with fluid restriction indicated that the patient stated that the patient stated that the patient indicated that the patient or include acceptance the outside clinics / fatige 2. Clinical record nured for care), included a physician for the cert 03/09/16. a. Section 14 of equipment) and suppose care, indicated the patient of the pa	ted that she received dialysis day, and Friday. The OASIS as in a narrative, "Patient has dialysis on Monday ay." The Plan of Care ate that the patient was atments. For patient number 2 occurred AM. During the home visit at she was on a 1500 calorie fons. The plan of care (POC) cient was on a regular diet. For dated 1/26, 2/2, and and clinic and a physician tion clinic dated 2/5/16 were of care failed to be updated the of physician orders from accilities Figure 1, SOC 05/15/15 (start blan of care established by a diffication period of 01/10/16 to a skin condition warranting the estimates of the plan of attent was being supplied to the skin condition warranting the plan of care. For existing 1 was reviewed. An order was reviewed. An order	N 524			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STATE	ZIP CODE	•	
			W 62ND ST	, 2 332		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	NAPOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 524	Continued From page 18		N 524			
	daily. The plan of car	g Atorvastatin 10 milligrams re failed to be revised and patient's current medication				
	3. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16.					
	plan of care indicated Creon [medication for 76,000 - 120,000 unit Saccharomyces Boul [milligrams] 1 tab dail every 6 hours as nee	y, acetaminophen 325 mg ded for pain. Section 17 of licated the patient was				
	12/29/15, indicated the with Creon 24,000 3 saccharomyces was of medications, and a tabs every 6 hours the summary also indicated the summary also indicated the with the creation of the summary also indicated the with the creation of the	ed the patient was allergic to lfate and niaspan, but also				
	02/18/16 at 10:30 a.n was not familiar nor d saccharomyces medi care failed to be upda	e visit with the patient on n., the patient stated he / she lid he / she know what cation was. The plan of ated and revised to include ect medications with accurate cy.				
	included an establish	mber 5, SOC 02/01/16, ed plan of care by a fication period of 02/01/16 to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	•	
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	62ND ST			
	T	INDIAN	APOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 524	Continued From page 19		N 524			
	03/31/16.					
	skilled nursing facility	e discharge paperwork from a dated 01/14/16, indicated gic to Albuterol, Lexapro, and				
	 b. Section 17 of the Allergy section of the plan of care indicated the patient was only allergic to Duricef. The plan of care failed to include allergies to Albuterol and Lexapro. 5. Clinical record number 6, SOC 02/08/16, included a plan of care established by a physician for the certification periods of 02/08/16 to 04/07/16, with orders for skilled nursing, physical, and occupational therapy. 					
	admission assessme Registered Nurse ind patient's care, was to cardiovascular and re daily weights, edema	espiratory status, monitor , and shortness of breath s a history of congestive				
	the patient's had a tra lower extremities. In the Registered failed as obtaining / assess each visit, when to no increase in weight du	ue to fluid retention, and on sodium restrictions / diet				
	the patient was not ta	ed Nurse also had indicated aking an anticoagulant. In of care and medication				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S	
AND FLAN	DF CORRECTION	IDENTIFICATION NUMBER.		A. BUILDING:		COMP	ETED
		011129		B. WING		02/2	24/2016
NAME OF P	ROVIDER OR SUPPLIER	STR	EET ADDR	ESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	4 W 62NI				
	Г		IANAPO	LIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
N 524	Continued From page	e 20		N 524			
	profile, the patient wa (anticoagulant medica daily. The plan of car interventions such as and safety measures	is taking Xarelto ation) 15 mg (milligrams) re failed to include education, assessment, and measurable goals.					
	c. M1302 asked if the patient was at risk for developing pressure ulcers. The answer provided was "no." M2250 asked if the physician ordered plan of care include interventions to prevent pressure ulcers. The answer provided was "NA [not applicable] Pressure ulcer risk assessment [clinical or formal] indicates patient is not at risk of developing pressure ulcers." The Braden scale indicated the patient scored a 16,						
			S				
	which indicated the podeveloping pressure	atient is at a low risk of ulcers. The plan of care ventions to prevent skin					
	lesion or open wound interventions by the a assessment was revi- nurse within the office changed from "no" to agreed to the change care failed to include	igency. The OASIS ewed by quality assurance e and the question was "yes". The admitting nurse of answers. The plan of the cite of the skin lesion o include the interventions					
	included a plan of car	mber 7, SOC 01/27/16, re established by a physicial eriod of 01/27/16 to 03/26/16					
	admission assessment M1730 asked if the padepression, using a s	e OASIS comprehensive nt dated 01/27/16, line atient had been screened fo tandardized validated tool. The answer provided					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		011129	B. WING		02/	24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	62ND ST APOLIS, IN 4626	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 524	different standardized the patient meets critic depression." The plat and updated to include for depression. 7. Clinical record nur 10/18/15, included and the certification period with orders for skilled 5 weeks to " perfor patient and caregiver" The plan of care foam dressing to be usuction settings for the upon admission. a. Review of the Podiatry visit note dainot limited to the follo Combigan 0.2 - 0.5 % twice a day; Glucosal mg two tablets twice at twice a day, Imdur EF Multivitamin daily. Sefailed to evidence the listed. b. The podiatry visit also indicated the pation of care indicated the pation of care indicated the pation of care indicated. b. The podiatry visit note day also indicated the pation of care indicated.	at was screened with a di, validated assessment and deria for further evaluation for an of care failed to be revised de interventions and goals of the interventions at week for the intervention of the plan of the intervention of the plan of the intervention of the intervention of the intervention of the intervention of the plan of the intervention o	N 524			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		011129	B. WING		02/24/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	
BROOKD	ALE HOME HEALTH IND	ANAPOLIS 5354 W 6 INDIANA	2ND ST POLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
N 524	of clinical record (Poli December, 2012) star record will be maintai receiving care. The consumption of sufficient information describe the patient's care, accurately docuresults in detail, and famong organization at The procedure related "[r]elevant diet or diet included in the clinical of the commentation and/or 2/24/16 at 2:20 PM. 10. A policy titled "Cantal 2/2012, indicated " controlled Food or droutcomes to be achied treatments supplies Frequency and durating decisions and services made as a result of the analysis of initial and	and their dosage. and procedure for contents cy No. HH:2-055.1; revised tes as follows: "A clinical need for each patient dinical record will contain to identify the patient, problems and needs, justify ment care provided and acilitate continuity of care and contract personnel." If to said policy indicates that ary restrictions, in any" be I record for skilled patients. and Director of Clinical to provide any additional or information when asked on the clinical plan of care any allergies goals / wed medications and so and equipment required	N 524		
N 532	410 IAC 17-13-1(d) P	atient Care	N 532		
	Rule 13 Sec. 1(d) Hopersonnel shall promphysician or other approfessional staff and	otly notify a patient's			

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		(X1) PROVIDER/SUPF	TION NUMBER			COMPLETE	
				A. BUILDING: _			
		011129		B. WING		02/	24/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62I	ND ST OLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFOI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
N 532	for occupational thera for four weeks starting Review of the occupatindicated the occupational make a second visit of the clinical record fair physician had been in the missed visits.	sical or mental charby the patient. In the patient. In the patient	he case th agency y system he agency are d visits in nd failed iificant (# 9) I/16, physician 3/13/16. equency a week /17/16. notes, ed to 01/21/16. at the manner of I 01/29/16, eight loss cal record en notified	N 532			
	10/18/15, with an esta certification period of	ablished plan of ca	re for the				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		011129	B. WING		02	2/24/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	-	
BROOKDA	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 6	2ND ST POLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
N 532	orders for skilled nurs five weeks, physical to one week, and occup week for one week. a. Review of the Comparison Report", attempted to schedule hospitalized), 10/24 (p 10/28 (patient / careg (scheduling error), an skilled nursing service the admission assess b. A "Client Coor 10/28/15, indicated care continue, but the patie The note indicated the follow up with primary c. A "Client Coor 11/05,15, indicated the follow up with primary c. A "Client Coor 11/05,15, indicated the follow up with primary 3. The Administrator Services was unable documentation and/or 2/24/16 at 2:20 PM. 4. A policy titled "Nut 12/2012, indicated " comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration and the comprehensive asses alteration in nutritional make a referral to a quality of the comprehensive asses alteration in nutritional make a re	"Visits to Orders the skilled nurse had e visits on 10/20 (patient patient / caregiver refused), iver refused), 10/30 d 11/03/15 (patient declined e). The only visit made was ament on 10/18/15. Indication Note Report" dated are was projected to ent had been refusing visits. The case manager was to a care physician. Indication Note Report" dated at the primary care of the patient's refusal and of from services. The clinical from services. The clinical from the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a care that the physician had ely manner of the missed on the case manager was to a case manager was to	N 532			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011129	B. WING		02/24/2016
					1 02/24/2010
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 6 INDIANA	2ND ST POLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 532	Continued From page	25	N 532		
	the physician (or othe independent practition for a nutritional consults. A policy titled "Ass Reporting To Physicia" Clinicians will esta	r authorized licensed her) contact and the order lt " essing Patient's Response / hn" dated 12/2012, indicated ablish and maintain ongoing he physician to ensure safe			
N 537		home health agency shall	N 537		
		ses by a registered nurse or urse in accordance with the as follows:			
	include initial and ong interventions and goar reviewed (# 3); failed included names of ph can accept orders from reviewed (# 3); skilled frequency in the plan reviewed (# 8, 9, 10); ordered in the plan of reviewed of patients wand failed to follow wo	ew and interview, the ed to ensure the plan of care oing wound treatments with ls for 1 of 12 records to ensure the plan of care ysicians that the clinicians			
	Findings include:				
		nber 3, SOC 01/18/16, e established by a physician riods of 01/18/16 to			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING: _		COMPL	.ETED
		011129		B. WING		02/2	24/2016
NAME OF PI	ROVIDER OR SUPPLIER	ST	REET ADDR	RESS, CITY, STA	TE, ZIP CODE		
DD00KD		53	54 W 62N	D ST			
BROOKDA	ALE HOME HEALTH IND	INI	DIANAPO	LIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 537	Continued From page	e 26		N 537			
	03/17/16.						
	00/1//10.						
	admission assessment primary diagnosis ind necrotizing faciitis. Of atrial fibrillation, coror leg syndrome, chronicuse of anticoagulants		m				
	b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided						
		eel which included cleaning	g				
	=	ter, applied moisturizer the					
		d 4 x 4 gauze, foam heel, and secured with paper tap	_				
		d to include the admitting	·				
		nt, as well as interventions					
	and goals that were to	o be provided by the agend	cy.				
	orders from the woun and 02/16/16, and ord coagulation clinic date the plan of care indica agency "may accept of physicians: All treating	ecord evidence physician and clinic dated 01/27, 02/02 ders from a physician at the ed 02/05/16. Section 21 of ated the home health orders from the following and consulting." The placecific in the acceptance of	e f an				
	11/18/15, included a physician for the certi 01/16/16, with orders a week for one week,	mber 8, SOC [start of care] plan of care established by ification period 11/18/15 to for skilled nursing one time, two times a week for 2 a week for one week.	а				

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	OF DEFICIENCIES	(X1) PROVIDER/S		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATI	ON NUMBER:	A. BUILDING: _		COMPL	EIED
		011129		B. WING		02/2	4/2016
NAME OF B		011120	STDEET ADD	DESS CITY STA	TE ZID CODE	1 02/2	.4/2010
NAME OF P	ROVIDER OR SUPPLIER		5354 W 62N	RESS, CITY, STA JD ST	IE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS		OLIS, IN 46268	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFIC		ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECED LSC IDENTIFYING IN	ED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLETE DATE
N 537	Continued From page 27			N 537			
	a. Review of the the skilled nurse failed the patient during were 11/28/15). During were made a visit without a skilled nurse failed to b. A physician's indicated a new skilled time a week for one were every other week time 12/27/15 to 01/02/16, visits and during the wold of 01/09/16, the skilled repatient without a pskilled nurse failed to 3. Clinical record nurincluded a plan of carfor the certification per	skilled nursing d to make a sec ek two (11/22/19) ek five, the skilled physician's order dated 12/d nursing frequeveek then one ties 2. During the the skilled nursing seek of 01/03/11 nurse made one ohysician's order follow the plan mber 9, SOC 01 the established by	cond visit to 5 to ed nurse der. The of care. 20/15, ency of one me a week e week of the made two 6 to e extra visit to er. The of care. /14/16, y a physician				
	with orders for skilled one week then two tir	-					
	a. A physician's indicated effective 01 to see the patient two three times a week for a week for one week. nursing visit notes incomade an extra nursin during the week of 2/2 third nursing visit during the skilled nurse failed.	/24/16, the skilled times a week for two weeks, the Review of the licated the skilled govisit (total of the 24/16 and failed and the week of the ded to follow the licated the skilled govisit (total of the week	ed nurse was or one week, en two times skilled ed nurse hree visits) I to make a 02/07/16. plan of care.				
	b. A physician's indicated for skilled no PT/INR on 02/23/16. evidenced the skilled 2/18/16, and obtained nurse failed to follow	ursing to reched The clinical red nurse made a v I the PT/INR. T	ck the ord visit on 'he skilled				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION		E SURVEY PLETED
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 6	2ND ST POLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 537	Continued From page	28	N 537			
	included a plan of car for the certification pe with order for skilled rone week, two times at then one time a week and teach decubitus cleanse with normal sfoam dressing. a. Review of the made a visit on 2/9/16 nurse failed to follow b. Review of the 2/09, 02/12, 02/16, 02 wound care section in provided decubitus cleanse with normal stonsting skin barrier with duoderm. The silled rone with order section in provided The silled rone with duoderm. The silled rone with order section in provided The silled rone with order rone with duoderm. The silled rone with order rone rone with order rone rone rone rone rone rone rone ro	skilled nursing visits on 2/19, and 02/23/16, the adicated, "wound care care to L [left] buttock				
	Services was unable documentation and/or 2/24/16 at 2:20 PM. 6. A policy titled "Car 12/2012, indicated " . include Food or dru outcomes to be achie treatments supplies Frequency and durati decisions and service made as a result of the analysis of initial and	ved medications and s and equipment required				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011129	B. WING		02/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 62			
	I		OLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 541	Rule 14 Sec. 1(a) (1) are limited to therapy practice in the home I nurse shall do the foll (B) Regularly reevaluneeds.	nealth setting, the registered owing: uate the patient's nursing	N 541		
	within a timely manne	ew and interview, the ed to assess patient wounds er and per agency policy for red of patients with wounds			
	Findings include:				
	01/18/16, included a p	nber 3, SOC (start of care) plan of care established by a fication period of 01/18/16 to			
	dated 02/02/16, indica	rder from the wound clinic ated for skilled nursing to nent to the bilateral lower weeks.			
	the clinical record evidence Practical Nurse) made between 02/04/16 to assessment by regist	ered nurse was made on ed nurse failed to reassess			
	11/18/15, included a p	mber 8, SOC [start of care] blan of care established by a fication period 11/18/15 to			

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	ND DI AN OF CODDECTION		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		011129	B. WING		02	2/24/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
BROOKE	OALE HOME HEALTH IND	IANAPOLIS 5354 W 6	S2ND ST POLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 541	01/16/16, with orders a week for one week weeks, then one time a. A skilled nurs indicated the patient wound to the left low note dated 12/14/15, requested Employee Wound Nurse, asses did not see the patier 12/10/15 to 12/21/15 areas, two partial thic pretibial lower leg and The registered nurse assess the patient's I timely manner. b. A skilled nurs indicated the patient's I timely manner. c. A skilled nurs indicated the register to the three wounds, the wounds had not be d. A skilled nurs with visits and was not time due to a wound healed. The visit not wounds had not beer e. Review of the the clinical record fail	for skilled nursing one time, two times a week for 2 a week for one week. Ing visit note dated 12/10/15, had a weeping / oozing er leg. A skilled nursing visit indicated the patient L, a Registered Nurse / s her wound. Employee L at until 12/21/15. Between the patient developed three exhess wounds to the mid done to the left lateral ankle. failed to follow up and eft lower leg wounds within a sing visit note dated 12/28/16, s had two left partial ne mid - pretibial lower leg to the left lateral ankle. The red during this time. Ing visit note dated 01/04/16, ed nurse provided treatment but failed to evidence that open measured. Ing visit note dated 01/07/16, ing was going to continue of discharging at the present that was not completely e failed to evidence that the neasured. It would be the skilled nursing visit notes, ed to evidence a visit by the eassessment of the wounds	N 541				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SUR COMPLETE	
		011129		B. WING		02/24/2	2016
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	ANAPOLIS	354 W 62N NDIANAPC	ID ST DLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
N 541	Continued From page	: 31		N 541			
	included a plan of car for the certification pe with orders for skilled a. A physician or indicated the skilled in treatments to an unkr b. Review of skill 02/08/16 and 02/11/1 nurse performed treatments in the precipital area. The	rder dated 01/20/16, urse was to perform wou nown area. led nursing visit notes dated, indicated the registered them to the right anterior ne visits notes failed to ents of the wound for both dical record failed to asurements between	nd ted				
	included a plan of car for the certification pe with orders for skilled decubitus care to the	nber 10, SOC 12/10/15, e established by a physic riod of 02/09/16 to 04/04/ nursing to perform / teac left upper buttock.	/16, h				
	clinical record evidend a week between 02/0	ced a LPN made visits tw 9/16 and 2/19/16. The d to reassess the patient's	ice				
	Services was unable	and Director of Clinical to provide any additional r information when asked	on				
N 542	410 IAC 17-14-1(a)(1)(C) Scope of Services		N 542			
	Rule 14 Sec. 1(a) (1)	(C) Except where service	s				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C		1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY
				A. BUILDING: _			
		011129		B. WING		02	/24/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62N				
			INDIANAPO	OLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 542	Continued From page	e 32		N 542			
	are limited to therapy practice in the home nurse shall do the foll	re limited to therapy only, for purposes of ractice in the home health setting, the registered urse shall do the following: C) Initiate the plan of care and necessary evisions.					
	plan of care to include the patient, wound ca interventions and me	ew and interview, the ed to update and revise all medications taken bure supplies, allergies, asurable goals, and outsed for 7 of 12 records	ру				
	Findings include:						
	reviewed on 02/18/16 record had an establithe physician for certito 04/12/16, with order	I for patient number 2 was at 10:30 AM. The clinic shed plan of care signed fication periods of 02/13 ers for skilled nursing on reek, two days a week for eek for two weeks.	cal d by 6/16 e				
	on 02/18/16 at 9:30 At the patient was obseron the her left forearn whether she was curripatient number 2 station Monday, Wednesd dated 02/13/16, state renal failure and has Wednesday and Frida (POC) failed to indicate receiving dialysis treat	ay." The Plan of Care that the patient was	sit stula to llysis ASIS : has				
		M. During the home vis					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i	CONSTRUCTION		SURVEY PLETED
			A. BUILDING: _			
		011129	B. WING		02	/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	62ND ST APOLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 542	diet with fluid restriction indicated that the pattern indicated indicated include acceptance the outside clinics / fattern included acceptance the outside clinics / fattern included acceptance the outside clinics / fattern included acceptance included apphysician for the certifoly included apphysician for the certifoly included apphysician for the certifoly included acceptance included apphysician for the certifoly included and revise included incl	t she was on a 1500 calorie ons. The plan of care (POC) ient was on a regular diet. Inder dated 1/26, 2/2, and and clinic and a physician tion clinic dated 2/5/16 were of care failed to be updated as of physician orders from acilities. Inder 1, SOC 05/15/15 (start alan of care established by a diffication period of 01/10/16 to the DME (durable medical alies portion of the plan of atient was being supplied a clinical record failed to skin condition warranting the plan of care. Visit with the patient on s clinical record with the ty was reviewed. An order	N 542			
	1. Section 10 of	the medication portion of the				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION		E SURVEY PLETED
		011129	B. WING	· · · · · · · · · · · · · · · · · · ·	02	2/24/2016
	PROVIDER OR SUPPLIER ALE HOME HEALTH INC	DIANAPOLIS 5354 V	T ADDRESS, CITY, STATE W 62ND ST NAPOLIS, IN 46268	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 542	plan of care indicated Creon [medication for 76,000 - 120,000 uni Saccharomyces Boul [milligrams] 1 tab dai every 6 hours as need the allergy portion in allergic to neomycin 2. A hospital dis 12/29/15, indicated the with Creon 24,000 3 saccharomyces was of medications, and at tabs every 6 hours the summary also indicated not only neomycin sutto neomycin otic and 3. During a homo 02/18/16 at 10:30 a.r. was not familiar nor of saccharomyces medicate failed to be updall allergies and corredosages and frequer 4. Clinical record nuincluded an establish physician for the cert 03/31/16. a. Review of the skilled nursing facility the patient was allergouricef. b. Section 17 of of care indicated the	d the patient was taking or pancreatitis] 24,000 - ts, 2 tabs 3 times a day, lardii oral, 250 mg ly, acetaminophen 325 mg eded for pain. Section 17 of dicated the patient was sulfate and niaspan. Scharge summary dated the patient discharged home tabs 3 times a day, no listed on the discharged list acetaminophen 2 - 500 mg tree times a day. The ted the patient was allergic to allfate and niaspan, but also neosporin. The visit with the patient on the patient stated he / she did he / she know what ication was. The plan of ated and revised to include ect medications with accurate ncy.	N 542			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02/24/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 6	_			
	I		POLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLI THE APPROPRIATE DATE	ETE
N 542	Continued From page	e 35	N 542			
	allergies to Albuterol	allergies to Albuterol and Lexapro.				
	included a plan of car for the certification pe	for skilled nursing, physical,				
	a. Review of the OASIS comprehensive admission assessment dated 02/08/16, the Registered Nurse indicated the main focus of the patient's care, was to assess / evaluate cardiovascular and respiratory status, monitor daily weights, edema, and shortness of breath due to the patient has a history of congestive heart failure and atrial fibrillation.					
	the patient's had a tra lower extremities. In the Registered failed as obtaining / assess each visit, when to no increase in weight du	e to fluid retention, and n sodium restrictions / diet				
	the patient was not ta reviewing of the plan profile, the patient wa (anticoagulant medica daily. The plan of cal interventions such as and safety measures c. M1302 asked developing pressure	ation) 15 mg (milligrams) re failed to include education, assessment, and measurable goals. if the patient was at risk for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NOW	IDEK.	A. BUILDING: _		COMP	LETED
		011129		B. WING		02	/24/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BBOOKD	ALE HOME HEALTH IND	IANADOLIS	5354 W 621	ND ST			
BROOKD	ALL HOME HEALTHIND	IANAFOLIS	INDIANAPO	OLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 542	was "NA [not applical assessment [clinical on the trisk of developing Braden scale indicated which indicated the property of the trisk of developing pressure failed to include interpretated by the trisk of the trisk of	ers. The answer proviole] Pressure ulcer ristor formal] indicates particled the patient scored attent is at a low risk of ulcers. The plan of caventions to prevent sk surable goals. If the patient had a skill that was receiving agency. The OASIS ewed by quality assure and the question was "yes". The admitting of answers. The plan the cite of the skin lesso include the intervent	k atient is The a 16, of are in kin ance s nurse n of sion tions 6, pysician 3/26/16. ve e ned for	N 542			
	indicated "yes, patien different standardized the patient meets crit depression." The pla	tool. The answer pro it was screened with a d, validated assessme eria for further evaluat n of care failed to be i de interventions and g	a ent and tion for revised				
	10/18/15, included ar	mber 11, SOC (start on start) on established plan of cold of 10/18/15 to 12/16	are for				

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011129	B. WING		02/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	•
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 62 INDIANAP	ND ST OLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 542	5 weeks to " perfor patient and caregiver, " The plan of care foam dressing to be usuction settings for thupon admission. a. Review of the Podiatry visit note dat not limited to the follo Combigan 0.2 - 0.5 % twice a day; Glucosar mg two tablets twice a twice a day, Imdur EF Multivitamin daily. Se failed to evidence the listed.	nursing 2 times a week for m / teach wound care to the wound vac to RLE diabetic failed to include the type of sed, draping, and the e wound vac to be used patient's most recent ed 10/13/15, included, but wing medications: 45 grams APP AA solution mine - Chondroitin 500 400 a day; Nitro Bid 2% apply 1" R 60 mg daily, and a ection 10 of the plan of care prescribed medications	N 542		
	also indicated the pat 50 mg, 1/2 tab twice a Vitamin E 200 U, 2 cathe plan of care indicated 50 mg of Lopressor to Berberine - Hops oral (micrograms) - 90 mg Vitamin E - Vitamin C 100 Units - 100 mg - medications on the placcurate medications 8. The agency policy of clinical record (Poli December, 2012) state record will be maintain receiving care. The consultance of the patient's	- Magnesium - Zinc oral 10 mg - 18 mg. The an of care failed to provide and their dosage. and procedure for contents cy No. HH:2-055.1; revised res as follows: "A clinical ned for each patient linical record will contain			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		011129	B. WING		02	2/24/2016
	ROVIDER OR SUPPLIER ALE HOME HEALTH IND	IANAPOLIS 5354 W	ADDRESS, CITY, STATE 62ND ST APOLIS, IN 46268	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 542	among organization a The procedure relater "[r]elevant diet or diet included in the clinical 9. The Administrator Services was unable documentation and/o 2/24/16 at 2:20 PM. 10. A policy titled "Ca 12/2012, indicated ". include Food or droutcomes to be achie treatments supplies Frequency and duratif decisions and service made as a result of the analysis of initial and analysis of patient reseand outcomes" 11. A policy titled "Ca 12/2012, indicated ". include Food or dro outcomes to be achie treatments supplies Frequency and duratif decisions and service made as a result of the analysis of initial and include Food or dro outcomes to be achie treatments supplies Frequency and duratif decisions and service made as a result of the analysis of initial and	facilitate continuity of care and contract personnel." d to said policy indicates that ary restrictions, in any" be all record for skilled patients. and Director of Clinical to provide any additional r information when asked on the are Planning Process" dated and equipment required and equipment required and equipment required and equipment process, ongoing assessments, and exponse to care against goals are Planning Process" dated and equipment required and exponse to care against goals are Planning Process and equipment required and equipment equ	N 542			
N 543)(D) Scope of Services (D) Except where services only, for purposes of	N 543			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BROOKD	ALE HOME HEALTH INI	DIANAPOLIS	62ND ST APOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 543	practice in the home nurse shall do the fo (D) Initiate approprize rehabilitative nursing. This RULE is not meased on record reverse and dietician in regards weight loss for 1 of 1 with weight loss in a serior the certification per Patient diagnoses in failure, atrial fibrillation chronic kidney diseased. A skilled nursindicated the patient since his / her hospif failed to indicate if the fother significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed to indicate if the significant weight loss in a serior that the patient since his / her hospif failed in the patient since his / her hospif failed in the failed	health setting, the registered llowing: ate preventive and g procedures. et as evidenced by: iew and interview, the iled to address / consult with a to a patient's significant a record reviewed of a patient sample of 12. (# 9) Imber 9, SOC 01/14/16, are established by a physician eriod 01/14/16 to 03/13/16. clude but not limited to, heart on, diabetes mellitus II, and use stage five. Sing visit note dated 01/22/16, had a weight of 197 pounds Ising visit note dated 01/29/16, had a 20 pound weight loss talization. The clinical record use physician had been notified ght loss. In was unable to provide any ation and/or information /16 at 2:50 PM. Autritional Assessment" dated When the initial and essment indicates an al status, the clinician will	N 543			

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011129	B. WING		02/24/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 62 INDIANAF	ND ST POLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 543	Continued From page	40	N 543		
	the physician (or othe	ner) contact and the order			
N 545	410 IAC 17-14-1(a)(1))(F) Scope of Services	N 545		
	are limited to therapy practice in the home in nurse shall do the followard for the coordinate service. This RULE is not met Based on interview are failed to ensure their effectively and documenters that was furnitive records reviewed (# 2 receiving outside service) disciplines providing secondinated effectively.	nealth setting, the registered owing: res. It as evidenced by: nd record review, the agency efforts were coordinated rented with the dialysis shing services for 2 of 2 and 11) of patients rices, and failed to ensure all service to patients			
	Findings include:				
	reviewed on 02/18/16 record had a plan of ophysician for certificat 04/12/16, with orders week for one week, tw and 1 day a week for a. A home visit fo on 02/18/16 at 9:30 A the patient was obser	ion periods of 02/13/16 to for skilled nursing one day a vo days a week for 3 weeks,			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		011129	B. WING		02	/24/2016
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	•	
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 6 INDIANA	2ND ST POLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
N 545	whether she was current patient number 2 state on Monday, Wedness the care coordination evidence coordination agency and the dialysta. 2. Clinical record number included a plan of care for the certification per with orders for skilled and occupational the evaluation visit dated was no coordination occupational therapist documented efforts with the occup the case manager. b. Review of the evaluation visit dated was no coordination of the case manager. b. Review of the evaluation visit dated was no coordination of the case manager. 3. Clinical record number included a plan of care for the certification per with orders for skilled and occupational therapist dated was no coordination of the certification per with orders for skilled and occupational therapist dated was no coordination of the evaluation visit dated was no coordination o	rently receiving dialysis, ed that she received dialysis day, and Friday. Review of notes, the agency failed to notes, the agency failed to note care between the sis center. Imber 7, SOC 01/27/16, re established by a physician eriod of 01/27/16 to 03/26/16, nursing, physical therapy, rapy. In physical therapy initial 01/27/16, indicated there of services with the strand skilled nursing. The orevidence that the physical distributional therapist and with the coccupational therapy initial 02/03/16, indicated there of services with physical cursing. The clinical record at the occupational therapist coordination efforts with the direct with the case manager. Imber 8, SOC 11/28/15, re established by a physician eriod of 11/28/15 to 01/26/16, nursing, physical therapy, rapy.	N 545			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	-	
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 63 INDIANAI	2ND ST POLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
N 545	therapist documented efforts with the occup the case manager. b. Review of the evaluation visit dated was no coordination of therapy and skilled not failed to evidence that documented his / her physical therapist and 4. Clinical record nur included a plan of car for the certification per a. A skilled nursi indicated that the RN from the physician off 2/2/16. b. A skilled nursi indicated that the LPN the patient. The clinic written documentation services related to co specimen to be obtain c. Review of the evaluation visit dated was no coordination of therapy and skilled not failed to evidence that documented his / her physical therapist and	o evidence that the physical I his / her coordination ational therapist and with e occupational therapy initial 11/23/15, indicated there of services with physical ursing. The clinical record the occupational therapist coordination efforts with the with the case manager. Inber 9, SOC 01/14/16, we established by a physician wind 01/14/16 to 03/13/16. Ing visit note dated 01/29/16, obtained a verbal order fice to repeat an INR on the coordination of the coordina	N 545			
		01/19/16, indicated there				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLE	ILD
011129 B. WING 02/24	1/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BROOKDALE HOME HEALTH INDIANAPOLIS 5354 W 62ND ST INDIANAPOLIS, IN 46268	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 545 Continued From page 43 occupational therapist and skilled nursing. The agency failed to ensure efforts were coordinated effectively. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager. 5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15. The plan of care diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center. 6. An interview with the Administrator on 02/18/16 at 2:25 PM, stated that the agency does "not typically keep records from dialysis care, or communicate directly with the dialysis clinic." 7. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see. 8. A policy titled "Continuity of Care" dated 12/2012, indicated " Periodic communication between team members concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes F. Coummunicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to be provided" 9. A policy titled "Case Conference / Progress	

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011129	B. WING		02/24/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	,
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 6			
BROOKE	I	INDIANA	POLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 545	Continued From page	44	N 545		
	· ·	s - both direct and contract vith patients will participate			
N 546	410 IAC 17-14-1(a)(1))(G) Scope of Services	N 546		
	are limited to therapy practice in the home hourse shall do the followard (G) Inform the physic medical personnel of condition and needs, family in meeting nurs	nealth setting, the registered owing: ian and other appropriate changes in the patient's counsel the patient and sing and related needs, e programs, and supervise			
	failed to ensure prima notified within a timely 2 of 12 records review to notify the physician	t as evidenced by: ew and interview, the agency ry care physicians are manner of missed visits in wed (# 9 and 11) and failed of a patient's significant record reviewed. (# 9)			
	Findings include:				
	included a plan of car	nber 9, SOC 01/14/16, e established by a physician riod 01/14/16 to 03/13/16.			
	for occupational thera for four weeks starting Review of the occupa indicated the occupati	py was two times a week g week starting 01/17/16. tional therapy visit notes, ional therapist failed to uring the week of 01/21/16.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 62	ND ST OLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
N 546	The clinical record fai physician had been not the missed visits. b. A skilled nursi indicated the patient is since his / her hospital failed to indicate if the of the significant weig. 2. Clinical record nur 10/18/15, with an esta certification period of orders for skilled nursifive weeks, physical to one week, and occup week for one week. a. Review of the Comparison Report", attempted to scheduling error), and skilled nursing serviced (scheduling error), and skilled nursing serviced the admission assess. b. A "Client Coordo 10/28/15, indicated continue, but the patient of the physician was notified was being discharged record failed to evident.	led to evidence that the otified in a timely manner of ang visit note dated 01/29/16, and a 20 pound weight loss alization. The clinical record exphysician had been notified that loss. The roll of the state of the 10/18/15 to 12/16/15, with sing two times a week for the ational therapy one time a week for ational therapy one time a week for ational therapy one time a "Visits to Orders the skilled nurse had exists on 10/20 (patient poatient / caregiver refused), iver refused), 10/30 d 11/03/15 (patient declined exp.). The only visit made was ament on 10/18/15. Tradination Note Report dated are was projected to the early size of the case manager was to a care physician.	N 546		

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011129	B. WING		02/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 62 INDIANAP	ND ST OLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 546	Continued From page	: 46	N 546		
	Services was unable documentation and/or 2/24/16 at 2:20 PM.	and Director of Clinical to provide any additional information when asked on rtional Assessment" dated			
	12/2012, indicated " comprehensive asses alteration in nutritiona make a referral to a q professional for furthe 3. Documentation in the physician (or othe	When the initial and ssment indicates an I status, the clinician will ualified health care or nutritional assessment the clinical record will reflect r authorized licensed ner) contact and the order			
	Reporting To Physicia " Clinicians will esta	essing Patient's Response / un" dated 12/2012, indicated ablish and maintain ongoing ne physician to ensure safe for the patient "			
N 547	410 IAC 17-14-1(a)(1)(H) Scope of Services	N 547		
	are limited to therapy practice in the home I nurse shall do the foll (H) Accept and carry	nealth setting, the registered			
	This RULE is not me Based on record revie agency failed to ensu- outside facilities were pertinent and specific rate, and strength with	ew and interview, the re orders provided by clarified and had all information including route,			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		011129	B. WING		02	2/24/2016
NAME OF P	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STATE	E, ZIP CODE		
BROOKD	ALE HOME HEALTH IN	DIANAPOLIS	W 62ND ST NAPOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 547	#12); failed to include be obtained periphe 2 patient records refailed to include all I physician's order for of patient's with wou order for speech the receiving speech the patient records. Findings include: 1. Clinical record not 01/14/16, included a physician for the ce 03/13/16. a. A physician' indicated for the ski dressing, cleanse with dressing, cleanse with foar order failed to include b. A skilled nur indicated in the narr Tuesday 2/2/16." The put into writing, sign nurse. c. A physician indicated for a skilled 02/23/16. The orde PT/INR was to be oby finger stick. d. Review of the clinical record evided dated 01/25, 01/27, 0	wed with Intravenous fluids (de include if a PT/INR was to stally or by finger stick for 1 of viewed getting PT/INRs (#9); ocations of wounds in a r 1 of 5 records reviewed (# 9) ands, and failed to write an erapy for 1 of 2 patient's erapy (# 9) in a sample of 12 umber 9, SOC (start of care) a plan of care established by a rtification period 01/14/16 to s order dated 01/20/16, lled nurse to "remove old ound with normal saline, pat in dressings." The physicians de location of the wound. sing visit note dated 01/29/16, rative note "Repeat INR next he verbal order failed to be red, and dated by the skilled order dated 02/09/16, d nurse to obtain a PT/INR on r failed to include if the btained by peripheral stick or ne therapy visit notes, the nce speech therapy visits 02/03, and 02/08/16. The to evidence an order for	N 547			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED		
		011129		B. WING		02/2	24/2016
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62N INDIANAPO	ND ST DLIS, IN 46268	В		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
N 547	Continued From page	e 48		N 547			
	speech therapy.						
	2. Clinical record number 12, SOC 11/10/15, included an established plan of care for the certification periods of 11/10/15 to 01/08/16.						
	a. A physician o indicated "HH [home 500 ml [milliliters] NS repeat tomorrow." The residential living nurs have the ordered clar of the normal saline, patient needed a perior if the patient alread central line for route.	[normal saline] now, ne order was taken be. The agency failed ified to include the strate of infusion, and in pheral IV started for	then y the I to trength if the infusion				
	3. The Administrator Services was unable documentation and/o 2/24/16 at 2:20 PM.	to provide any additi	onal				
	4. A policy titled "Intr Medications / Solution " All orders for IV in specify medication nat type and amount, rou administration, and rat medications and solut administered throught venous line "	ns" dated 12/2012, in medications and solut ame and dosage, dilu ite, frequency of ate of infusion IV tions will only be	ndicated tions will uent				
N 550	410 IAC 17-14-1(a)(1)(K) Scope of Servic	es	N 550			
	Rule 14 Sec. 1(a) (1) are limited to therapy practice in the home nurse shall do the foll (K) Delegate duties a	only, for purposes of health setting, the relowing:	f gistered				

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		(X1) PROVIDER/SUPPLIER/CLIA	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.11.2 7.27.11		1521111110111101111011152111	A. BUILDING: _		33 22.23	
		011129	B. WING		02/24/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W (INDIANA	S2ND ST APOLIS, IN 46268	В		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLE	ETE
N 550	Continued From page	± 49	N 550			
	practical nurses and appropriate.					
	failed to ensure that t	ew and interview, the agency he home health aide written urate in relation to the				
	Findings include:					
	1. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by the physician for the certification period of 01/18/16 to 03/17/16, with orders for home health aide services to provide assistance with personal care and activities of daily living.					
	a. A home health aide written plan of instructions dated 01/18/16, indicated for the home health aide to provide a shower, shampoo, and skin care one time a week for 5 weeks.					
	AM, the patient verbal her first bath in 6 mor verbalized he / she hashower due to his illn unsteady gait. The pbeen getting sponge	atient indicated he / she had bathes at the sink. The ten care instructions failed				
	Services was unable	and Director of Clinical to provide any additional r information when asked on				

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Indiana State Department of Health

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STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII DING:		COMPLETED	
			1 3.250			
		011129	B. WING		02/24/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
avic Of T				, 0001		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 6		n		
		INDIANA	POLIS, IN 4626	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IAIE DAII	_
				·		-
N 553	410 IAC 17-14-1(a)(2)(A) Scope of Services	N 553			
	Rule 14 Sec. 1(a) (2)	For purposes of practice in				
	the home health setting	ng, the licensed practical				
	nurse shall do the foll	owing:				
	(A) Provide services	in accordance with agency				
	policies.					
	This RULE is not me	t as evidenced by:				
	Based on record revie	ew and interview, the agency				
		PN [Licensed Practical				
		gency administrative policy /				
	_	ards to communicating with				
		irse] and / or Director of				
	Professional Services	=				
		eveloping integumentary				
		ower extremity for 1 of 5				
	_	a patient receiving services				
	from a LPN. (# 8)	i a patient receiving services				
	Finding include:					
	i mang molado.					
	1 A job description t	for an LPN dated 12/2012,				
		al functions 3. Performs				
		ent during each visit and				
	documents data inpat					
	_	icant findings, problems, or				
	changes in the patien					
		or Director of Professional				
		sician and documents all				
	findings, communicat					
		nents nursing interventions				
	including patient resp	onse "				
	0 01:-: 1					
		nber 8, SOC (start of care)				
		olan of care established by a				
		fication period 11/18/15 to				
	01/16/16.					
	 a. A skilled nursi 	ing visit note dated 12/10/15,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			RVEY FED		
		011129		B. WING		02/24	/2016
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62N INDIANAPO	ID ST DLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
N 553	indicated the patient on LLE [left lower ext was noted. SN [skille and help in taking car [patient] refused comher dermatologist saidermatitis and it will hereord failed to evide RN / Director of Profess. The Administrator Services was unable documentation and/o 2/24/16 at 2:20 PM. 4. A policy titled "Scot 12/2012, indicated " vacation nurses suppneeds of the patient and nurse. These include accordance with orgat Preparing clinical and the registered nurse is specialized procedure.	nad a weeping / oozin remity] anterior lower ed nurse] offered to interest of that wound but the pletely and stated that did that this is contact real by self." The clinicate that the LPN notificational Services. and Director of Clinicate provide any addition information when as the people of Service dated and the control of the cont	half terfere ne pt t his / cal ied the al nal ked on al / are istered s in esisting ning sting	N 553			
N 555	410 IAC 17-14-1(a)(2)(C) Scope of Service	es	N 555			
	practical nurse shall of	health setting, the lice to the following: ian and/or registered					
	I = -	-	а				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP		` ′	CONSTRUCTION	(X3) DATE	SURVEY
ANDILAN	or connection	IDENTIFICATION	NOMBEN.	A. BUILDING: _		COM	LLILD
		011129		B. WING		02	24/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62I				
			INDIANAPO	DLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEI Y MUST BE PRECEDEI LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 555	Continued From page	e 52		N 555			
	to document treatments that were being provided in accordance to physician orders in 3 of 5 records reviewed of patients with wounds. (# 3, 8, and 10)						
	Finding include:						
	 Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16, with orders for skilled nursing 2 times a week for 6 weeks. a. A physician order from the wound clinic dated 01/26/16, indicated three ulcer areas to be treated. 1. An ulcer to the right anterior leg measuring 3.5 cm x 1 cm x 0.1 cm. The 						
	treatment included to with sterile water and times a week for 1 we heel measuring 1.8 c	cleanse the per i- moisturize the dr eek. 2. An ulcer t	- ulcer area y skin 3 to the left				
	treatment included to with plain water and relegs, apply a nickel thagent] to the wound, foam heel, hydrogel, for 1 week. 3. An uld measuring 1.7 cm x 0 treatment included to plain water. Use vick dressing, place a pactoes, daily for 1 week.	cleanse the peri- moisturize the hee nick layer of Santy followed by 4 x 4 kerlix, and paper to the right 2nd 0.8 cm x 0.1 cm. cleanse the wour s vapor rub as the l between left 3rd	- ulcer area els and rl [debrding gauze, tape daily d toe The nd with e primary and 4th				
	1. A skilled 01/28/16, indicated the to the bilateral lower aseptic technique per assessment failed to location (left heels, right 2nd digit toe), assess	extremity wounds orders. The skill evidence the spec ght anterior leg, ar	vound care under ed nursing cific nd right				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	62ND ST			
		INDIANA	APOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 555	Continued From page	e 53	N 555			
	provided to the bilateral extremity wounds.					
	01/30/16, indicated the care to the bilateral lost provided an assessm LPN failed to evidence	nursing visit note dated le LPN performed wound le LPN performed wound le LPN l				
	01/31/16, indicated the care to the bilateral lo provided an assessm LPN failed to evidence	nursing visit note dated the LPN performed wound to the left heel. The especific locations of the essment (right anterior leges).				
	02/01/16, indicated the care to the bilateral lost provided an assessm LPN failed to evidence	nursing visit note dated le LPN performed wound le wer extremities. The LPN lent to the left heel. The le specific locations of lessment (right anterior leg				
	dated 02/02/16, indical ulcer measured 3 cm treatment included to with sterile water and times a week for 1 we indicated an ulcer to 1 cm x 0.8 cm x 0.1 cm cleanse the peri - ulcomoisturize the heels a [medicated dressing], foam heel, kerlix and The right 2nd digit toe	rder from the wound clinic ated the right anterior leg x 1 cm x 0.1 cm. The cleanse the per i- ulcer area moisturize the dry skin 3 ek. The order also the left heel measuring 1.5. The treatment included to the area with sterile water and and legs, apply PRISMA followed by 4 x 4 gauze, tape daily for two weeks. The ulcer measured 0.8 cm x at treatment included to				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		011129	B. WING		02	2/24/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
BROOKE	ALE HOME HEALTH INC	DIANAPOLIS	62ND ST APOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 555	cleanse the wound wapor rub as the prin between left 3rd and 1. A skilled 02/04/16, indicated to care to the bilateral leprovided an assessment LPN failed to evident wounds and their assand right 2nd digit to 2. A skilled 02/05/16, indicated to care to the bilateral leprovided an assessment LPN failed to evident wounds and their assand right 2nd digit to 3. A skilled 02/06/16, indicated to care to the bilateral leprovided an assessment LPN failed to evident wounds and their assand right 2nd digit to 4. A skilled 02/07/16, indicated to care to the bilateral leprovided an assessment LPN failed to evident wounds and their assand right 2nd digit to 5. A skilled 02/08/16, the narration 5.	with plain water. Use vicks hary dressing, place a pad 4th toes, daily for 2 weeks. nursing visit note dated he LPN performed wound ower extremities. The LPN hent to the left heel. The ce specific locations of sessment (right anterior leg ee). nursing visit note dated he LPN performed wound ower extremities. The LPN hent to the left heel. The ce specific locations of sessment (right anterior leg ee). nursing visit note dated he LPN performed wound ower extremities. The LPN hent to the left heel. The ce specific locations of sessment (right anterior leg ee). nursing visit note dated he LPN performed wound ower extremities. The LPN hent to the left heel. The ce specific locations of sessment (right anterior leg ee).	N 555			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 6	2ND ST POLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
N 555	Continued From page	÷ 55	N 555		
		t heel. The LPN failed to ent to the right anterior leg			
	02/09/16, the narrativ performed wound car yet the treatment port and their treatment. assessment to the lef	t heel. The LPN failed to ent to the right anterior leg			
	7. A skilled nursing visit note dated 02/10/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.				
	02/11/16, the narrative performed wound car yet the treatment port and their treatment. assessment to the lef	t heel. The LPN failed to ent to the right anterior leg			
	02/12/16, the narrativ performed wound car yet the treatment port and their treatment. assessment to the lef	t heel. The LPN failed to ent to the right anterior leg			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		, , ,	E SURVEY PLETED
			A. BUILDING:			
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 6	_			
	CLIMMADY CT		POLIS, IN 46268	DDOVIDEDIS DI AN OF	CORRECTION	200
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 555	Continued From page	e 56	N 555			
	02/13/16, the narrative performed wound care yet the treatment port and their treatment. The assessment to the left evidence an assessment right 2nd digit to be a series of the treatment performed wound care yet the treatment port and their treatment. The assessment to the left of the treatment of the left of the treatment of the left of the treatment of the left of the treatment.	theel. The LPN failed to then to the right anterior leg to the right anterior leg to the left heel only, but the LPN grovided an theel. The LPN failed to the right anterior leg				
	02/15/16, the narrative performed wound carreyet the treatment port and their treatment. The assessment to the left evidence an assessment right 2nd digit to evidence and right 2nd digit and right 2nd digit	theel. The LPN failed to the to the right anterior leg e. The LPN failed to the right anterior leg e. The Research of the right anterior leg e.				
	was noted. A skilled	remity] anterior lower half nursing visit note dated le patient had a wound, but				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02/24/2016
	ROVIDER OR SUPPLIER	IANAPOLIS 5354 W	ADDRESS, CITY, STAT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	APOLIS, IN 46268 ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
N 555	3. Clinical record nur included a plan of car for the certification pewith order for skilled rone week, two times at then one time a week and teach decubitus cleanse with normal sfoam dressing. a. Review of the made a visit on 2/9/16 nurse failed to follow b. Review of the 2/09, 02/12, 02/16, 02 section indicated, "widecubitus care to L [le normal saline, pat dry to surrounding tissue, skilled nurse failed to 4. The Administrator Services was unable	assessment of the wound. mber 10, SOC 12/10/15, re established by a physician period 02/09/16 to 04/04/16, nursing one time a week for a week for three weeks, refor two weeks to perform care to left upper buttock, realine, pate dry, cover with skilled nursing visits, a LPN and 2/12/16. The skilled	N 555		
N 560	by the home health a (1) a physical thera assistant supervised therapist in accordance (2) an occupational	y therapy services furnished gency shall be provided by: pist or physical therapist by a licensed physical ce with IC 25-27-1; or therapist or occupational pervised by an occupational	N 560		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPF		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION	NUMBER.	A. BUILDING: _		COMP	LETED
		011129		B. WING		02	/24/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PPOOKD	ALE HOME HEALTH IND	IANADOLIS	5354 W 62I	ND ST			
BROOKD	ALE NOME REALIN IND	IANAPOLIS	INDIANAPO	OLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFOI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 560	Continued From page	= 58		N 560			
	(3) a speech-language pathologist or audiologist in accordance with IC 25-35.6. This RULE is not met as evidenced by:						
	This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the occupational and physical therapy follow the therapy frequency in the plan of care for 5 of 9 records reviewed in a sample of 12. (# 3, 8, 9, 10, and 11)						
	Findings include:						
	1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16.		physician				
	a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing facilitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants.		the had cluded , restless				
	had a stage II pressumeasured 2 x 1.3 x 0 wound was described. The note indicated the treatment to the left had the site with plain was heel and legs, applied wrapped with kerlix, and ongoing treatment and goals that were to	.1 cm [centimeters d as partial thickned e skilled nurse properties which included ter, applied moistured 4 x 4 gauze, foar and secured with p d to include the adnt, as well as intervals	neel that]. The ss wound. vided I cleaning rizer the n heel, aper tape. mitting ventions ne agency.				
	orders from the woun						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/G		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBI	ER:	A. BUILDING: _		COMP	LETED
				D WING			
		011129		B. WING		02/	24/2016
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
BROOKDA	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62N	ND ST DLIS, IN 46268	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
N 560	Continued From page	e 59		N 560			
	and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan of care failed to be specific in the acceptance of physician orders. 2. Clinical record number 8, SOC [start of care]						
	2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.		l by a 5 to time				
	a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care.		e e				
	indicated a new skille time a week for one wevery other week time 12/27/15 to 01/02/16, visits and during the w 01/09/16, the skilled in the patient without a p	nurse made one extra v physician's order. The	eek of two isit to				
	skilled nurse failed to follow the plan of care. 3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks and occupational therapy two times a week for four weeks starting week starting 01/17/16.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		011129	B. WING	B. WING		02/24/2016	
	ROVIDER OR SUPPLIER	5354 W 62	DRESS, CITY, STA	TE, ZIP CODE			
BROOKE	ALL HOME HEALTHIND	INDIANAP	OLIS, IN 46268	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 560	indicated effective 01 to see the patient two three times a week for a week for one week, nursing visit notes inc made an extra nursin during the week of 2/2 third nursing visit duri The skilled nurse faile b. Review of the notes, indicated the of to make a second vis 01/21/16. The occup follow the plan of care c. A physician's indicated for skilled no PT/INR on 02/23/16. evidenced the skilled 2/18/16, and obtained nurse failed to follow 4. Clinical record nur included a plan of car for the certification pe with order for skilled r one week, two times a then one time a week and teach decubitus of cleanse with normal se foam dressing. a. Review of the made a visit on 2/9/16 nurse failed to follow	order dated 01/20/16, /24/16, the skilled nurse was a times a week for one week, or two weeks, then two times Review of the skilled dicated the skilled nurse g visit (total of three visits) 24/16 and failed to make a ng the week of 02/07/16. The detectional therapy visit occupational therapist failed it during the week of ational therapist failed it during the week of ational therapist failed to be. Order dated 02/09/16, ursing to recheck the The clinical record nurse made a visit on the PT/INR. The skilled the plan of care. In the PT/INR. The skilled the plan of care. In the PT/INR the skilled the plan of care week for three weeks, a for two weeks to perform the care to left upper buttock, staline, pate dry, cover with the skilled nursing visits, a LPN of and 2/12/16. The skilled	N 560				
		2/19, and 02/23/16, the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) I			
		011129	B. WING		02	/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	N 62ND ST NAPOLIS, IN 46268	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
N 560	wound care section in provided decubitus cleanse with normal s nonsting skin barrier with duoderm. The s the plan of care. 5. Clinical record nur 10/18/15, included ar the certification period with orders for physic for one week and occ a week for one week. therapy failed to follow 6. The Administrator Services was unable documentation and/o 2/24/16 at 2:20 PM. 410 IAC 17-14-1(c)(2 Rule 14 Sec. 1(c) The listed in subsection (b) (c) review the plan of the worder with the plan of the provided services.	andicated, "wound care is care to L [left] buttock saline, pat dry, apply to surrounding tissue, cover killed nurse failed to follow mber 11, SOC (start of care) in established plan of care for d of 10/18/15 to 12/16/15, all therapy one time a week supational therapy one time. Physical and Occupation with plan of care. and Director of Clinical to provide any additional information when asked on Scope of Services be appropriate therapist of this rule shall:	N 560			
	failed to ensure that t performed a compreh recertification in the la certification period for	et as evidenced by: ew and interview, the agency he registered nurse nensive assessment for ast 5 days of the 60 day				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		011129	B. WING	B. WING		/24/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS 5354 W 6	2ND ST POLIS, IN 46268	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 563	11/18/15, included a physician for the certif 01/16/16. a. The clinical recomprehensive reass The skilled nurse faile comprehensive asses between the dates of 2. The Administrator Services was unable documentation and/o 2/24/16 at 2:20 PM. 3. A policy titled "Init Assessment" dated 1 comprehensive patier completed The last day episode beginnin (recertification) " 4. A policy titled "Rea Recertification" dated comprehensive asses and revised every 60 OASIS assessment frames: A. recertification prepisode of care, a conwill be completed no before and no later the	cord evidenced a essment dated 01/21/16. est to complete the essment for recertification 01/12/16 to 01/12/16 to 01/12/16 to 01/16/16. end Director of Clinical to provide any additional r information when asked on tial and Comprehensive 2/2012, indicated "A ent assessment will be tive (5) days of every 60 - g with the start of care date	N 563			
N 565	410 IAC 17-14-1(c)(4 Rule 14 Sec. 1(c) Th) Scope of Services e appropriate therapist	N 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		011129	B. WING		02	2/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	62ND ST APOLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 565	listed in subsection (k (4) help develop the necessary); This RULE is not me Based on record reviet therapist failed to inclivists with speech, phytherapy and if the patagreement with the previewed of patients is sample of 12. (# 8, 9, Findings include: 1. Clinical record nur 11/18/15, included a physician for the certiform occupational therapy a. Review of the evaluation visit dated therapy assessment prequency of the propinclude if the patient is agreement with the p b. Review of the evaluation visit dated assessment plan failed of the proposed visits patient / representative plan of care. 2. Clinical record nur included a plan of care for the certification per section in the certification per section in the certification per section.	o) of this rule shall: plan of care (revising as It as evidenced by: ew and interview, the ude frequency of proposed ysical, and occupational ient / representative was in lan of care in 3 of 9 records receiving therapy in a and 12) The state of the s	N 565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMP	LETED
		011129	B. WING	B. WING		24/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	62ND ST APOLIS, IN 4626	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
N 565	Continued From page	e 64	N 565			
	a. Review of the occupational therapy initial evaluation visit dated 01/18/16, failed to include the frequency of the proposed visits.b. Review of the physical therapy initial					
	evaluation visit dated 01/19/16, failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.					
	3. Clinical record number 12, SOC 11/10/15, included a plan of care established by a physician for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services.					
	a. Review of the occupational therapy initial evaluation visit note dated 11/13/15, the occupational therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care.					
	evaluation visit note of therapy assessment frequency of the prop	e speech therapy initial dated 11/13/15, the speech plan failed to include the cosed visits and failed to representative was in lan of care.				
	Services was unable	and Director of Clinical to provide any additional r information when asked on				
N 566	410 IAC 17-14-1(c)(5) Scope of Services	N 566			
	Rule 14 Sec. 1(c) Th	e appropriate therapist				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		
		011129	B. WING		02/24/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	1 02/24/2010
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 6	2ND ST		
BROOKD	ALL HOME HEALTH INDI	INDIANA	POLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
N 566	Continued From page	: 65	N 566		
	listed in subsection (b) of this rule shall: (5) prepare clinical notes;				
	completed at the end provide for 1 of 4 reco	ew and interview, eech therapy failed to ge summary had been			
	Findings include: 1. Clinical record number 12, SOC (start of care) 11/10/15, included an established plan of care for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services. a. Review of the occupational therapy visit notes, the occupational therapist last visit was made on 12/03/15. The occupational therapist failed to complete a discharge summary.				
		•			
	Services was unable	and Director of Clinical to provide any additional rinformation when asked on			
N 567	410 IAC 17-14-1(c)(6) Scope of Services	N 567		
	Rule 14 Sec. 1(c) Th listed in subsection (b	e appropriate therapist) of this rule shall:			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5354 W 62ND ST INDIANAPOLIS, IN 46268 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) N 567 Continued From page 66 (6) advise and consult with the family and other home health agency personnel; This RULE is not met as evidenced by: Based on record review and interview, the Occupational and Physical therapist failed to ensure to coordinate with other therapists and case managers and document their efforts for 3 of 9 patients receiving multiple (therapy) services in a sample of 12. (# 7, 8, and 9) Findings include: Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BROOKDALE HOME HEALTH INDIANAPOLIS (X4) ID PREFIX TAG (EACH DEFICIENCY) MUST BE PRECEDED BY FULL TAGS (6) advise and consult with the family and other home health agency personnel; This RULE is not met as evidenced by: Based on record review and interview, the Occupational and Physical therapist failed to ensure to coordinate with other therapists and case managers and document their efforts for 3 of 9 patients receiving multiple (therapy) services in a sample of 12. (# 7, 8, and 9) Findings include: Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial	744512744	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _			
BROOKDALE HOME HEALTH INDIANAPOLIS SUMMARY STATEMENT OF DEFICIENCIES INDIANAPOLIS, IN 46268			011129	B. WING	B. WING		24/2016
INDIANAPOLIS INDIANAPOLIS (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONSS.REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONSS.REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG COSS.REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG COSS.REFERENCED TO THE APPROPRIATE DATE (BACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG COSS.REFERENCED TO THE APPROPRIATE DATE (BACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CONSS.REFERENCED TO THE APPROPRIATE DATE (BACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG COMPLETE TAG CONSS.REFERENCED TO THE APPROPRIATE DATE (BACH COMPLETE TAG COMPLETE T	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 567 Continued From page 66 (6) advise and consult with the family and other home health agency personnel; This RULE is not met as evidenced by: Based on record review and interview, the Occupational and Physical therapist failed to ensure to coordinate with other therapists and case managers and document their efforts for 3 of 9 patients receiving multiple (therapy) services in a sample of 12. (# 7, 8, and 9) Findings include: Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial	BROOKD	ALE HOME HEALTH IND	IANAPOLIS		В		
(6) advise and consult with the family and other home health agency personnel; This RULE is not met as evidenced by: Based on record review and interview, the Occupational and Physical therapist failed to ensure to coordinate with other therapists and case managers and document their efforts for 3 of 9 patients receiving multiple (therapy) services in a sample of 12. (# 7, 8, and 9) Findings include: Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	IOULD BE	COMPLETE
evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager. b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager. 3. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16,	N 567	(6) advise and consult home health agency process and consult home health agency and consult he case managers and consult he case managers and consult health agency in a sample of 12. (#Findings include: Clinical record numbers a plan of care establist certification period of orders for skilled nurs occupational therapy. a. Review of the evaluation visit dated was no coordination of coccupational therapist clinical record failed to the case manager. b. Review of the evaluation visit dated was no coordination of the case manager. b. Review of the evaluation visit dated was no coordination of the case manager. 3. Clinical record nursincluded a plan of care and consult herapist and countered his / her physical therapist and countered applan of care and consult herapist and countered his / her physical therapist and countered his / her physi	alt with the family and other personnel; It as evidenced by: It as evidence therapists and document their efforts for 3 grandtiple (therapy) services It as a physician for the only of	N 567			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE SURVEY COMPLETED	
74101 2741	or connection	ibertii io/morti	iomber.	A. BUILDING: _			
		011129		B. WING		02	/24/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62N INDIANAPO	ND ST DLIS, IN 46268	3		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 567	Continued From page 67			N 567			
	and occupational therapy.						
	a. Review of the evaluation visit dated was no coordination occupational therapis clinical record failed therapist documented efforts with the occup the case manager.	of services with the t and skilled nursing o evidence that the I his / her coordinati	I there g. The physical ion				
	b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager.						
	4. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16 with orders for skilled nursing, physical therapy, and occupational therapy.						
	a. Review of the evaluation visit dated was no coordination of therapy and skilled no failed to evidence the documented his / her occupational therapis manager.	of services with phy ursing. The clinical t the physical thera coordination efforts	I there sical record pist s with the				
	b. Review of the evaluation visit dated was no coordination occupational therapis clinical record failed therapist documented	of services with the t and skilled nursing o evidence that the	I there g. The physical				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02/24/2016
	20,425, 02,0425,452			TE 710 000E	02/24/2010
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 6 INDIANA	POLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 567	Continued From page	68	N 567		
	efforts with the occupational therapist and with the case manager.				
	5. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see.				
N 570	410 IAC 17-14-1(d) S	cope of Services	N 570		
	rule the therapist may (1) direct the activitie or	ied in subsection (c) of this			
	failed to provide supe therapy assistance ac certified occupational	ew and interview, the d Occupational Therapist rvision of the physical cording to Article 6 and therapy assistant according patient who had therapy			
	Findings include:				
	Therapists' Assistants Administrative Code) indicated " [g] Wisupervision of physica under IC [Indiana Coothe supervising physical)	6 - 1 - 2 Definitions			

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indiana S	state Department of He	aith				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			1			
			B. WING			
		011129	D. WING		02/2	4/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		5354 W 6	2ND ST			
BROOKD	ALE HOME HEALTH IND	IANAPOLIS	POLIS, IN 4626	8		
			TOLIS, IN 4020	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	17.0	DEFICIENCY)		
N 570	Continued From page	e 69	N 570			
	the physical therapist	's assistant shall consult				
	with the supervising p					
		ce each working day to				
	review all patients' tre					
	T = 1	a supervising physical				
	therapist or a physicia					
	therapist's assistant r					
	T	ecommunications device for				
		ng as there is interactive				
		erning patient care "				
	Communication conce	sming patient care				
	2 Article 10 Occup	ational Therapists and				
		y Assistants, 844 IAC 10 - 5				
	- 6 Documentation Se					
		t shall countersign within				
		ays all documentation				
		tional therapy assistant,				
	_	rt of the patient's permanent				
	record."	it of the patient's permanent				
	record.					
	2 Clinical record pur	mber 7, SOC 01/27/16 (start				
		lan of care established by				
	the physician for the					
		•				
		with orders for physical				
		eek for one week then two				
		veeks, and occupational				
		eek for one week then two				
	times a week for five	weeks.				
	a Davious of a	oon door a vioit ropert				
		pervisory visit report				
		tered nurse on 02/09 and				
		ne name of therapist being				
	evaluated. The regis					
		sical therapist] Employee F,				
		rapist], Employee G, COTA				
	[certified occupationa					
		Employee H, PTA [physical				
	therapy assistant].					
	b. Review of the	physical therapy assistant	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		011129	B. WING		02/24/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE HOME HEALTH INDI	ANAPOLIS 5354 W 62 INDIANAP	ND ST OLIS, IN 46268	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 570	note and the clinical rethe physical therapist assistant communicativisit was. c. Review of the therapy assistant note note and clinical record co-signature / communicativisit was. 4. Employee M, a PT Manager on 2/24/16 astated physical / occuphysical therapy assistant of the day are of the of the day as a communicative weekly signatures beto the Administrator and the physical of the physical of the day are of the of the day and the physical of the day are of the Administrator and the physical of th	cord failed to evidence that and the physical therapy and with each other after the certified occupational a dated 02/12/16, the visit and failed to evidence nication between the and the certified assistant. If and Therapy Service at 12:00 PM. Employee M pational therapist and stants / certified assistants would email and / lere was a need but was not ally communication to be PT and PTA, as well as ween OT and COTA.	N 570		
N 608	pertinent past and cur with accepted profess maintained for every p (1) The medical plan identifying information	nical records containing rent findings in accordance ional standards shall be patient as follows:	N 608		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER	ν.	A. BUILDING:			-LETED	
		011129		B. WING		02	/24/2016	
NAME OF PI	ROVIDER OR SUPPLIER	5	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
BROOKDA	ALE HOME HEALTH IND	IANAPOLIS	5354 W 62N					
			NDIANAPO	DLIS, IN 46268				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
N 608	8 Continued From page 71			N 608				
	(4) Signed and date to by all assigned pe be written the day serincorporated within for (5) Copies of summers person responsible for the patient's care. (6) A discharge summers on record revietable to ensure that of truthful and accurate (# 1 and 3), failed to einclude discharge sum	curteen (14) days. Hary reports sent to the part the medical component of the medical component of the medical component of the medical component of the medical visit notes were for 2 of 12 records reviewed of the clinical record of the maries from speech and for 1 of 9 record reviewed the medical record of the medical component of the medical componen	ed all t of ency ved					
	of care), included a p physician for the certi 03/09/16. The patien sacral debubitous ulc agency in September a. A home visit v	vas made with the LPN	y a 6 to a					
	(licensed practical nurse) on 02/18/16 at 8:15 a.m. The LPN was observed to calibrate the patient's glucometer, obtain blood sugar, inject insulin, obtained vital signs, and ask generalized assessments. The LPN did not assess the patient's skin in the coccyx area. The skilled nursing visit note indicated the LPN had performed a skin assessment. The LPN inaccurately documented an assessment that was not performed.							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
			D. WING									
		011129	B. WING		02/24/2016							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5354 W 62ND ST												
BROOKDALE HOME HEALTH INDIANAPOLIS INDIANAPOLIS, IN 46268												
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE							
N 608	Continued From page 72		N 608									
	2. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by the physician for the certification period of 01/18/16 to 03/17/16, with orders for home health aide services to provide assistance with personal care and activities of daily living. a. A home health aide written plan of											
	instructions dated 01/18/16, indicated for the home health aide to provide a shower, shampoo, and skin care one time a week for 5 weeks. b. Review of the home health aide visit notes, that are being performed by a licensed practical nurse, indicated the patient had received a shower on 01/28, 02/02, 02/09, 02/16/16.											
	AM, the patient verbal her first bath in 6 mor verbalized he / she has shower due to his illn unsteady gait. The p	atient indicated he / she had bathes at the sink. The LPN alth aide inaccurately										
	11/10/15, included an the certification period	mber 12, SOC (start of care) established plan of care for d of 11/10/15 to 01/08/16, ational and speech therapy										
	notes, the occupation	e occupational therapy visit all therapist last visit was The occupational therapist lischarge summary.										
	b. Review of the	speech therapy visit notes										

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		011129	B. WING		02/24/2016							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
BROOKDALE HOME HEALTH INDIANAPOLIS INDIANAPOLIS, IN 46268												
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE						
N 608	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		N 608									

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